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AUTHOR	Kadota, Riyo; Bennett, Tess; Thomas, Dawn
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ABSTRACT

The Great Lakes Quality Improvement Center for Disabilities (GLQIC-D) provides training and technical assistance regarding disabilities to Head Start and Early Head Start (EHS) programs. The GLQIC-D conducted a survey of Early Head Start programs in the Department of Health and Human Services Region V, including Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin. The survey probed the following areas: (1) preferred types of training and technical assistance for EHS staff; (2) issues/concerns and challenges EHS staff are facing; (3) types of disabilities served in EHS; and (4) the adaptations needed to provide services to children with disabilities. In addition to demographic data and census information on the programs and children with disabilities, major findings include the following: (1) the highest concern for programs was teenage parenting; (2) programs preferred varying types of training and assistance depending on their needs; and (3) the top three diagnosed disabilities were speech and language delay, asthma, and communication disorder. Either most Early Head Start staff did not interpret the children's disabilities as severe, or very few children with more severe disabilities were enrolled. (Contains 21 references.) (Author/HTH)

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Early Head Start: Services for Children with Special Needs and Staff Training Needs

Riyo Kadota, Tess Bennett, & Dawn Thomas

Abstract

The Great Lakes Quality Improvement Center for Disabilities (GLQIC-D) provides training and technical assistance regarding disabilities to Head Start and Early Head Start (EHS). This paper presents the findings of a GLQIC-D survey of Early Head Start programs in the Department of Health and Human Services Region V, including Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin. The survey probed the following areas: (1) preferred types of training and technical assistance for EHS staff, (2) issues/concerns and challenges EHS staff are facing, (3) types of disabilities served in EHS, and (4) the adaptations needed to provide services to children with disabilities. In addition to demographic data and census information on the programs and children with disabilities, major findings include the following: (1) the highest concern for programs was teenage parenting; (2) programs preferred varying types of training and assistance depending on their needs; and (3) the top three diagnosed disabilities were speech and language delay, asthma, and communication disorder. Most Early Head Start staff either did not interpret the children's disabilities as severe or very few children with more severe disabilities were enrolled.

Head Start (HS) has been a promising program for young children from low-income families for over three decades, providing comprehensive services such as education, disability services, health and nutrition, mental health, and parent education for the poorest of the nation. Early Head Start (EHS), a new initiative for low-income pregnant women and children from birth through 3, which began in 1995, offers comprehensive services to pregnant mothers and young children. Increasing numbers of pregnant women (teenage or low-income or both) have become a priority in the United States with the changes in legislation in welfare reform and family development (Children's Defense Fund, 1999; Lally & Keith, 1997). Because of the Personal Responsibility Reconciliation Act of 1996, also called welfare reform, a shortage of affordable child care for low-income families has emerged as an urgent problem for the population most affected by welfare reform. Strong partnerships between HS and community child care are essential. Head Start and Early Head Start programs are developing contractual agreements with community child care to create an optimal environment for children.

Few studies of EHS are available regarding the effectiveness of services for children with disabilities as well as other staff needs and challenges. There is a great need to study EHS, particularly regarding models for serving children with disabilities. HS, including EHS, is mandated within the scope of their federal regulations (Head Start Bureau, 1996) to keep at least 10% of enrollment opportunities open for children with disabilities. Utilizing HS and EHS as inclusive settings for children with disabilities remains a challenge at this time. The purpose of this study was to answer two questions: (1) how are children with disabilities served in EHS programs? and (2) what do EHS teachers report they need to know in order to carry out their work successfully?

In order to investigate what types of training and technical assistance EHS staff need, the Great Lakes Quality Improvement Center for Disabilities (GLQIC-D) conducted a joint needs assessment of the EHS programs (EHS Waves I and II—the EHS programs funded in 1995 and 1996) in 1998. GLQIC-D has been serving HS programs in Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin (Department of Health and Human Services Region V) since 1976. The GLQIC-D

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began serving Early Head Start (EHS Waves I and II) programs in Region V in 1995. At that time, the GLQIC-D began gathering annual information about EHS programs, children with disabilities, and training and technical assistance (T/TA) needs of EHS staff.

In this paper, information is presented about these 18 EHS Waves I and II programs in Region V. The survey probed the following areas: (1) preferred types of training and technical assistance for EHS staff, (2) issues/concerns and challenges EHS staff are facing, (3) types of disabilities served in EHS, and (4) the adaptations needed to provide services to children with disabilities. Historical perspectives of EHS, the concept and rationale of EHS, and recent issues of EHS are discussed in the next section.

Early Head Start

Early Head Start is a fully federally funded, community-based, comprehensive early childhood program designed for low-income pregnant women and families with infants and toddlers under age 3. Extracting some significant experiences and lessons from existing HS programs, EHS has implemented a simple, clear, and insightful mission from the beginning, which included the four cornerstones: (1) child development, (2) family development, (3) community-building basics, and (4) staff development (U.S. Department of Health and Human Services [DHHS], 1994). In order to ensure high-quality programming and to enhance the optimal development of infants and toddlers by building a strong relationship with parents, EHS has a formidable agenda. The federal commitment to EHS includes the provision of training and technical assistance, the implementation of Head Start Program Performance Standards (Head Start Bureau, 1996), and monitoring for high-quality programs, research and evaluation, and service coordination at the regional and national levels. In this section, four major bodies of literature are reviewed: (1) the history of EHS, (2) the importance of the first three years of life, (3) the legal impact of welfare reform on children with disabilities, and (4) strategies for staff training and technical assistance.

History of Early Head Start

When the Administration for Children, Youth, and Families (ACYF) in the Department of Health and Human Services (DHHS) initiated EHS, a community-based early childhood program focused on providing high-quality support for families living in impoverished environments and a high-quality early childhood education for their very young children, EHS was defined as "a child development program that seeks to enhance the development of infants and toddlers by establishing strong partnerships with parents" (Lally & Keith, 1997, p. 3). When the Head Start Bureau initiated EHS in fiscal year 1995, 68 EHS grantees were funded nationally serving about 5,000 children and 345 families (Head Start Act, 1998). According to the U.S. Department of Health and Human Services, in fiscal year 1999, 525 EHS grantees were funded nationally, and the services have been provided to approximately 40,000 children (DHHS, 2000).

The concept of EHS was derived from the Head Start program. The purpose of EHS is to enhance children's physical, social, emotional, and cognitive development; to enable parents to be better caregivers of and teachers to their children; and to help parents to meet their own goals, including that of economic independence (DHHS, 1994). To facilitate this effort, programs receiving EHS funding must build upon nine key principles: (1) high-quality care; (2) prevention and promotion; (3) positive relationships and continuity; (4) parent involvement; (5) inclusion; (6) culture; (7) comprehensiveness, flexibility, responsiveness, and intensity; (8) transition; and (9) collaboration (Lally & Keith, 1997).

The Importance of the First Three Years

The prenatal period and the first three years of life are the most critical period for facilitating healthy child growth and development in the physical, social, emotional, and cognitive areas. Biological outcomes and environmental factors must be taken into consideration for our youngest children. Ideally, all children from birth to age 3 should have a variety of experiences with their families in a peaceful, warm, positive, and safe environment.

Optimal environments for young children in the United States are not always possible because of domestic violence, drugs, and poor living conditions. Other social conditions, such as the increasing

number of low-income and teenage parents who lack economic security, education, and knowledge about child rearing and development also make very young children vulnerable. Fortunately, some recent studies identify the elements of the effective programs that enhance both child and family development (DHHS, 1999). It is important to focus on what we want for children and how we can support families. Based on these social changes and demands, the federal office has developed regulations to support HS and EHS. The following section describes the major legal impact on children with disabilities in EHS.

Legal Impact on Children with Disabilities in Early Head Start

The Individuals with Disabilities Education Act (IDEA) Amendments of 1997 (also called PL 105-17) were signed by President Clinton on June 4, 1997, and the Final IDEA '97 Regulations were released on March 12, 1999. The law legislates that states serve children with disabilities birth to 21 years of age. This law delineates the mandates regarding each specific age group. Part B outlines those ensuring services to individuals from 3 to 21. Part C (Early Intervention) outlines the services for young children, from birth to age 3. Just as in HS, EHS grantees are required to have at least 10% of their enrollment opportunities for children with disabilities and must actively recruit and enroll infants and toddlers with significant disabilities. In order to count toward the 10% mandate, the child must meet state-specific Part C eligibility criteria. This is facilitated by local interagency agreements. Early Head Start programs seek to build strong communities that serve the needs of all children and the inclusion of young children with disabilities and their families in their community. Early Head Start has many available resources. One of the supports is training and technical assistance (T/TA) funded by the Head Start Bureau in DHHS. The manner in which the T/TA system functions is presented in the following section.

Strategies of Staff Training and Technical Assistance

In order to provide additional training and technical assistance to EHS, the EHS National Resource Center (EHS NRC) was established in 1995. This center works with the 28 regionally funded Head Start Quality Improvement Centers (QICs) to provide T/TA to EHS. Information about disability services, program management/administration, health and nutrition, social services, facilities planning, and technical assistance services are coordinated and offered to both EHS and HS programs by these entities (Lally & Keith, 1997). Of the regionally funded QICs, 12 are called QIC-Ds and work only with disability issues. The GLQIC-D is one of these funded entities. Each Head Start QIC and QIC-D works cooperatively to ensure that all services are delivered in a comprehensive and integrated fashion to HS and EHS.

The GLQIC-D has historically gathered the information through annual needs assessments about T/TA needs of HS and EHS. The work of the GLQIC-D has been disseminated nationally through position papers, published reports, and articles in journals. Some examples of topics that the GLQIC-D staff have gathered information about are inclusion of children with disabilities (Kadota, Bennett, & Thomas, 1999a); service delivery in HS and EHS (Kadota, Bennett, & Thomas, 1999b); screening and assessment of children in HS, serving parents with disabilities in HS, and the impact of welfare reform on HS (Bhagwanji & Bennett, 1997); HS collaboration with child care (Bhagwanji & Bennett, 1998); challenging behaviors in children (Bennett & Deluca, 1995, 1996); writing interagency agreements (Buscemi, Bennett, Thomas, & Deluca, 1996); and the mental health of parents in EHS (Hojnar, Thomas, Stillwell, Bennett, & Allison, 1997). This information has been helpful in understanding the challenges that HS and EHS staff face in their everyday work in Region V. This paper summarizes the information gathered in 1998-1999 from 18 EHS programs in Region V.

Method

Procedures

A new protocol was designed to gather information from EHS about program demographics, census information, challenges, top-ranking issues, preferred types of training and technical assistance, types of disabilities served, and the amount of adaptation for

children with disabilities. A letter of invitation was sent to the directors of the EHS programs funded in 1995 and 1996 (also referred to as EHS Waves I and II), asking them to complete a survey with input from other staff members. The survey for assessing EHS needs was distributed to 26 EHS programs in November 1998. All surveys returned by March 15, 1999, were used in compiling this paper. The surveys were mailed out to 26 programs with a cover letter with a self-addressed stamped envelope for return.

Instrumentation and Data Analysis

In order to develop a new protocol, multiple resources were reviewed, including the *Head Start Program Information Report* (PIR) (Head Start Bureau, 1999), Head Start Program Performance Measures Second Program Report (DHHS, 1998a), Head Start Performance Standards (Head Start Bureau, 1996), Head Start Act (1998), and Individuals with Disabilities Education Act (IDEA) (1997). Also, GLQIC-D's annual survey studies from past years (e.g., Kadota, Bennett, & Thomas, 1999a, 1999b) were reviewed. Informal discussions were held with EHS program staff. The three-page survey contains six major sections: program demographics, census information, challenges/top-ranked issues, preferred types of training and technical assistance, types of diagnosed disabilities, and the amount of adaptation rate for children with disabilities. Answers to questions were by number, check mark, and lists. Additional spaces for comments were provided at the end of each section.

Two new sections were added to the survey at this time. One was a cross-reference check sheet. On the cross-reference check sheet, six major categories (e.g., General, Service Delivery, Child Issues, Welfare Reform, Family Issues, and Staff Issues) were determined based on the previous years' findings. Then, by utilizing five T/TA support types (e.g., Phone-TA, On-site TA, Distance Learning, College Credit, and Resource Library), a check sheet demonstrating the categories of needs and T/TA types was designed.

A section was developed in which EHS staff could also rate the amount of adaptation needed to serve children with disabilities. Early Head Start staff were asked to list examples of the disabilities of children enrolled in their program. Respondents were asked to rate the amount of adaptation for an individual child with a disability. The rating scale was 1 to 5. The number 5 indicated the highest amount of adaptation, and the number 1 denoted the least amount. Respondents were also asked to give the number of these children.

Data Analysis

Because of the sample numbers ($n = 18$), most of the numerical data were analyzed using descriptive statistics such as frequency, proportion/percentage, means, and standard deviation. All the data in this paper are presented as totals for Region V. These data were compared with other existing national reports (see the discussion section). The data were also portrayed in various graphic forms accompanied by explanatory notes.

Findings

Program Demographics

Surveys were sent to 26 EHS programs; 18 programs participated in the survey. The return rate was 69.2%. With regard to hours of operation of EHS, the mean times were 7:34 a.m. for opening and 5:19 p.m. for closing. Mean hours open per day were 9.75. Six programs reported providing services for 8-8.5 hours a day. However, half of the programs reported extended and flexible hours. Seven programs (41.2%) reported their program location as large, and five (29.4%) reported their location as small. No program reported their primary focus as center based (CB). Eight programs reported focusing on both center and home based (CB&HB), and eight other programs reported focusing only on home based (HB). Two programs reported focusing on home based and other (e.g., community child care, or play group).

Census Information

Eighteen programs reported serving 1,195 children (birth through age 3). All EHS programs offered the HB option, often in combination with CB. This CB option usually was offered within EHS itself or in collaboration with community agencies, such as child

care. From the data on HB, CB&HB, and HB and other centers programs (n = 18), each home visitor had a caseload of 6-10 families.

Information regarding families receiving Supplemental Security Income (SSI) and Child Care Assistance or Subsidies (CCA) was gathered. SSI assists families with a child with a disability. CCA is used to support a child for parents who are beginning job training or work. Eighteen programs reported 124 families (15.6%) receiving CCA only, 14 families (1.8%) receiving both CCA and SSI, and 53 families (6.7%) receiving SSI only. This information is useful in ascertaining the effect of welfare reform.

In terms of training and educational background of EHS staff members, there were 155 people with a degree (master's, bachelor's, or associate) or CDA credential. Bachelor's degrees were the most prevalent, followed by master's degrees, the CDA credential, associate degrees, and others. As to the major fields studied by EHS staff members, 108 people reported having some specialization: for example, 16.7% had an early childhood background, 5.6% were in early childhood special education, and 15.7% studied the field of child development.

Training and Technical Assistance Needs

The response to the section "Training and Technical Assistance Needs" revealed the areas in which EHS programs were challenged and the types of assistance preferred (e.g., Phone-TA, On-site TA, Distance Learning, College Credit, and Resource Library).

In response to the most important training and technical assistance needs, EHS programs reported "Teenage Parents" as most important, "HSFIS (Head Start Family Information System)" was second, and "Family Involvement" was third. "Teenage Parents" appeared in every category (some ranked 2 or 3), implying that it is the most challenging issue. Data indicated that the programs needed assistance on HSFIS. This came up under the category of Phone TA, On-site TA, and Distance Learning. Programs showed their interest in learning about prenatal issues through Distance Learning, College Credit, and Resource Library.

Regarding the types of assistance, On-site TA (n = 75) was the most popular strategy for programs, whereas College Credit (n = 7) was the least popular assistance among the programs. This result may suggest reduced awareness of College Credit as a method for training.

Children with Diagnosed Disabilities

On the last page in the survey, 259 of 1,195 children (21.7%) were reported as having some kind of disability. The top three diagnosed disabilities were (1) Speech and Language Delay (18.7%), (2) Asthma (14.0%), and (3) Communication Disorder (9.6%).

EHS staff were asked to give the number of children and rate from 1 through 5 (with 5 indicating the most and 1 the least) the amount of adaptation the program must make for a specific child with a disability. Among 259 children, no adaptation rate was given for 25 children with disabilities. The ratings 1-5 have been collapsed so that a rating of 4 or 5 represents severe, 3 is moderate, and 1 and 2 are mild. About 81.1 % of children in EHS programs were mildly disabled and needed little adaptation. Very few children received a rating of 5. The children who received this rating were often medically fragile. Examples of children who required a rating of 4 for adaptation were those with Down syndrome and autism. Examples of children who required moderate (rating 3) adaptation were health impairment/hydrocephalus, Down syndrome.

One of the difficulties for EHS was to distinguish the type of disability. Many EHS programs listed various types of disabilities that could be categorized as either developmental delay or at-risk. Because the states have different systems of categorizing children under Part C of IDEA, labels such as developmental delay were indicated under diagnosed disabilities as well as children at-risk. About 31.8% of the EHS programs reported serving children who were at-risk. In terms of the adaptation, none of these children received a rating of 4 or 5 (severe) on the adaptation category. With these disabilities (e.g., developmental delay or at-risk), EHS staff perceived that 37.7% of children in EHS programs were mildly disabled and 28.1% of children were moderately disabled.

Discussion

In order to interpret the findings of the GLQIC-D study, it is important to discuss a study carried out by the National Early Head Start Research and Evaluation Project (NEHSREP). In 1997, the NEHSREP collected data on 17 EHS programs and examined program characteristics and early implementation experiences. In December 1999, the first major executive summary report on this implementation, *Leading the Way: Characteristics and Early Experiences of Selected Early Head Start Programs, Volume I & II Executive Summary* (hereafter referred to as *Leading the Way*), was published by the Department of Health and Human Services (DHHS, 1999). Unlike the PIR data, types of protocols were not identified, and numerical data were not specifically presented in this publication. However, the general description provides broad information about the 17 EHS programs. As the sample number and contents in *Leading the Way* are similar to the GLQIC-D study, *Leading the Way* was utilized as a major resource for comparing data. In addition to *Leading the Way*, the Head Start *Statistical Fact Sheet* (DHHS, 1998b) and the PIR (Head Start Bureau, 1999) were used as additional resources for comparison.

Using the three major sources of data noted above to compare with GLQIC-D data, several themes were identified. Based on the findings, the following four themes appear as highlights of this study: (1) program options in EHS, (2) home visitors' caseloads, (3) EHS staff qualifications, and (4) proportion and types of disability.

Early Head Start Programs Offer Combination Options

In 1995, the Administration on Children, Youth, and Families (ACYF) awarded 68 EHS programs in 34 states, the District of Columbia, and Puerto Rico to serve more than 5,000 children under age 3. In 1996, 74 new EHS programs were selected to serve an additional 5,000 children and their families in 8 additional states. According to the PIR (Head Start Bureau, 1999), there are 260 EHS programs in all 50 states and in the District of Columbia and Puerto Rico, and 33,288 children under age 3 are served in the programs. About double that number have been funded to date, with the possibility of many more EHS programs to be funded in the future.

The numbers of EHS programs with a primary focus described as center based (CB), home based (HB), or combination (CB&HB) and children served at each EHS program were not separated out by the PIR (Head Start Bureau, 1999). Unfortunately, since the actual number of CB EHS programs is not in the PIR data, comparisons among numbers of EHS primary services are difficult. The current study found that, among 18 EHS programs in Region V, no programs reported their primary focus as center based (CB) only.

There are four options that EHS programs may offer to families and communities: (1) HB only, (2) CB only, (3) combination of HB and CB, and (4) locally designed options. For locally designed options, EHS may partner with community child care (either family or center based). The Head Start Bureau and the Region V office have instructed EHS programs to offer center based as an option. The major objectives of EHS are to be a family-centered and community-based program and to respond to the diverse needs of each local community and their children and families (Head Start Bureau, 1996). To meet these objectives, EHS must be a flexible program. Flexibility should be determined by the results of the community needs assessment. Community needs should guide the options offered to families. As *Leading the Way* (DHHS, 1999) states, "These changes in approach resulted from subsequent funding decisions, shifts in families' needs, and recommendations of technical assistance providers" (p. 6). Communities change and, therefore, so do EHS programs. Further research could explore how the EHS program interprets community needs assessment information and family needs and pursues setting up options, how children's disabilities are considered, and what issues are important for families.

Home Visitors' Caseloads

Caseload refers to the number of families per home visitor. In the GLQIC-D study, each home visitor had a caseload of 6-10. This number was lower than the reported caseload in *Leading the Way* (DHHS, 1999), which was 10-15, and those shown in PIR

(Head Start Bureau, 1999), which were 38.04 families per home visitor in the HS programs in Region V and 35.08 in the nation. The data illustrate that EHS in Region V seems to have an adequate number of home visitors to support children served in HB programs and their families. This finding could also relate to the proportion of children with disabilities (21.7%) in the programs. The more children with disabilities and their families served, the more support may be needed. An important question for future research would be "what are the additional responsibilities of home visitors when dealing with children with disabilities and their families?"

Staff Qualifications

In this study, 18.7% of EHS staff had a master's degree and 49.0% had a bachelor's degree. Although EHS staff are not required to possess a bachelor's degree or above, about 67.7% of the teaching staff in this study had this degree. Compared with *Leading the Way* (Head Start Bureau, 1999), the staff educational background in Region V is relatively high.

Staff specialization covers many fields in addition to early childhood education, such as adult education, social services, and counseling. Since the age range of the children is from birth to 3 and EHS programs have a mission to support pregnant women and low-income families, EHS programs may prefer to have a variety of personnel with varied backgrounds. Unfortunately, no comparison is available because there are no data for EHS programs presented in the PIR (data for HS were available) or *Leading the Way* on this matter.

Proportion and Types of Disabilities

The proportion of disabilities reported in *Leading the Way* (Head Start Bureau, 1999) was "at least 10%" in the majority of programs. Among the 17 research programs, 6 programs served about 15% of children with disabilities and another 6 programs served less than 10%. The total number of children served in EHS Region V was 1,195, with 21.7% of those children diagnosed as disabled ($n = 259$). This finding indicates that the EHS programs in Region V served children with disabilities more than Economic Opportunity Act Amendments (1972) mandated. This mandate ensured that 10% of enrollment opportunities will be given to children with disabilities (Economic Opportunity Act, 1972).

In addition, information about types of disabilities is also available in the GLQIC-D study. In terms of types of disability among the children, "Speech and Language Delay" (18.7%) appeared as the top diagnosed disabilities, followed by Asthma (14.0%) and Communication Disorder (9.6%). Although the same information for EHS programs is not presented in the PIR report, the data on "Number of children enrolled whose primary or most significant disability has been determined to be" for HS programs are listed (Head Start Bureau, 1999). These were "Speech or Language Impairments" as the most significant followed by "Non-Categorical/Developmental Delay" and "Health Impairment." Despite the different categorization utilized in the PIR (for HS programs) and GLQIC-D studies, a similar tendency was determined: "Speech and Language Delay" is listed as the most often served disability in both programs. This disability is generally seen as the least harmful label to give a child. This label may include children with behavior problems, learning disabilities, attention deficit disorder, attention deficit hyperactivity disorder, and other conditions. It is difficult to ascertain details about the characteristics of children with disabilities in HS and EHS because of the definition of the "at-risk" category and because each state has its own eligibility criteria for Part C Early Intervention. These factors need to be taken into consideration when analyzing data across states. A factor to be noted is that several states in Region V have a broad "at-risk" category as a part of their Part C funding criteria for serving infants and toddlers. EHS programs in those states may appear to have higher percentages categorized as "Speech and Language Delay"; however, consideration must be taken of the state-specific "at-risk" definitions.

Implications

Issues of Greatest Concern to EHS Programs

The EHS programs were asked to put their "Top Five Issues" among the 35 items listed in the survey. The highest concern for EHS programs was "Teenage Parenting." According to the *State of America's Children*, "One in eight of America's children was

born to a teenage mother" (Children's Defense Fund, 1999, p. xi). The teenage birth rate in the United States has been slowly declining steadily since 1991, but it still remains high (March of Dimes, 2000).

Teens may have inadequate eating habits and may take drugs, drink alcohol, or smoke. All of these factors may affect the infant and increase the risk of having a child with health problems. For example, if a teenager eats poorly, she may not gain an adequate amount of weight, which increases the risk that the baby will be born with a low birth weight. In 1997, 9.5% of teen mothers (ages 15 to 19) had an infant under 5.5 pounds, which is considered a low birth weight baby. Among teen mothers, the younger the mother, the more likely she is to have a low birth weight baby (e.g., 10.3% of mothers ages 15 through 17 years old had low birth weight babies, compared with 9.1% of mothers ages 18 to 19.4 (March of Dimes, 2000)). In some states, a child of a teenage mother is more likely to be labeled as at-risk or possibly disabled (March of Dimes, 2000).

EHS staff must deal with the everyday situations of young mothers and their children. To help in this area, many programs have requested assistance from the T/TA network and other local experts in their area. Challenges that require assistance may range from communication techniques with teen parents to family issues, such as domestic violence or substance abuse.

Types of Assistance the EHS Programs Preferred

The data indicated that EHS programs want varying types of training and technical assistance depending on their needs. For example, they might be likely to seek information on "Family Issues," such as Teenage Parent or Family with Substance Abuse Issues through On-site TA or Distance Learning. EHS staff noted that "Child Issues" (e.g., child health, nutrition, and safety) can be learned with College Credit. EHS staff preferred to learn about different topics through diverse methods.

Early Head Start Staff's Perceptions of Children with Disabilities

This study focused on the perception of the Early Head Start staff regarding severity of an individual child's disability and the resulting amount of adaptation required. The results of this tabulation have been discussed previously in this paper. Most EHS staff either did not interpret the children's diagnosed disabilities as severe or very few children with more severe disabilities were enrolled. In order to adapt settings for children with disabilities, the assessment of individual developmental differences is important. Future research could investigate the variables a staff member uses to rate the amount of adaptation for a child with a disability.

Conclusion

The findings of this study are important for those providing training and technical assistance to EHS. The most challenging issue for EHS was working with teenage parents. EHS staff were aware of many methods for T/TA. These topics and methods of delivery were outlined in this paper. We hope this information can assist T/TA providers in better understanding the challenges and concerns of EHS staff. Staff qualifications and detailed information regarding children with disabilities were presented. In addition, how staff perceived the adaptation of individual children with disabilities was indicated by a 5-point-scale rating system. Suggestions for further research were given.

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